(1) Supreme Court, U.S.
FILED

99 1453 MAR 2 2000

No. 99- OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

U.S. *ex rel.* A-1 AMBULANCE SERVICE, INC. *et al.*,

Petitioners,

v.

THE COUNTY OF MONTEREY, CALIFORNIA, and the COUNTY OF SAN MATEO *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Is possession of information by the United States Government a condition precedent for the application of 31 U.S.C. § 3730(e), the "public disclosure" bar of the Federal False Claims Act?

2. May Defendant(s) raise the public disclosure bar after the Attorney General has investigated the *qui tam* plaintiffs' case, declined to intervene and filed no other motion on behalf of the United States?

PARTIES TO THE PROCEEDINGS

Petitioners and the plaintiffs below are U.S. *ex rel.* A-1 Ambulance Service and Dennis B. Barrett.

The respondents are The County of Monterey, California, the County of San Mateo, California, Baystar Medical Services, and former Peninsula Paramedic Services, Inc. now doing business as American Medical Response.

Defendants named in the caption below: State of California, Daniel Smiley, County of Fresno, California, Sam Karas, Tom Perkins and Brian Sinnott were not named in the First Amended Complaint and not served below.

STATEMENT PURSUANT TO RULE 29.6

Petitioner A-1 Ambulance Service, Inc. has no parent corporation, and no publicly held company owns 10% or more of its stock.

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Petitioners respectfully petition for a writ of certiorari to review the Judgment of the United States Court of Appeals in *A-1 Ambulance Service, Inc. and Dennis B. Barrett v. State of California et al.*, Docket No. 98-115200, USDC No. CV-96-200048.

OPINIONS BELOW

This petition presents a Judgment of the Ninth Circuit. The unpublished District Court Order Granting Defendants' Motions to Dismiss was filed August 8, 1997 and is included at App. B. p. 15a. The Opinion of the Ninth Circuit Court of Appeals was filed on February 7, 2000 and is included at App. A, p. 1a.

STATEMENT OF JURISDICTION

The district court had original jurisdiction pursuant to 28 U.S.C. § 1331. The Court of Appeals entered its judgment on February 7, 2000. The Jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The following selected sections of the Civil False Claims Act, Title 31,

Section 3730(a) Responsibilities of the attorney general. — The Attorney General diligently shall investigate a violation under section 3729. * * *

Section 3730(b)(2): A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the

Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure . . .

Section 3730(b)(4): Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall — (A) proceed with the action, in which case the action shall be conducted by the Government; or (B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

Section 3730(e)(4)(A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

Selected sections of relevant California statutes are set forth in the Appendices.

STATEMENT OF THE CASE

Petitioner U.S. *ex rel.* A-1 Ambulance Service, Inc. has provided medical transportation services to the public in Monterey County, California since 1955. Petitioner U.S. *ex rel.* Dennis B. Barrett was A-1 Ambulance's operations manager and was professionally familiar, *inter alia*, with the costs of providing emergency ambulance services. In 1994, he obtained relevant documents from respondent County of San Mateo ("San Mateo") concerning its agreements with respondent Baystar Medical Services ("Baystar").

In the course of doing business, petitioners have billed and collected from patients and/or their private or federal government insurers for emergency ambulance services provided to them. Petitioners have also provided emergency ambulance services to State of California and Monterey County responsible indigent patients and billed and collected from the respective entities.

Since 1988, respondent County of Monterey ("Monterey") has asserted legal authority to regulate rates and to contract for emergency ambulance services within Monterey County. This assertion has lead to a number of lawsuits between A-1 Ambulance and Monterey County. The Court is respectfully directed to A-1 Ambulance Services, Inc.'s Petition for a Writ of Certiorari in *A-1 Ambulance Service, Inc. v. Robert J. Melton, M.D. et al.*, Docket No. 99-1217 ("A-1 Ambulance's Prior Petition") for this history.

Respondent Monterey published a Request for Proposal for Emergency Ambulance Services ("RFP") dated April 7, 1995. App. D, p. 28a. Respondent Monterey required that the franchise holder provide Advanced Life Support ("ALS") ambulance services for all calls within the exclusive franchise. App. D, p. 30a. "Advanced Life Support" means special services designed to provide definitive prehospital emergency medical care including cardiac resuscitation, advanced airway management, intravenous therapy and administration of drugs and other medicines under the supervision of a base hospital. *Calif. Health & Safety Code* § 1797.52. However, respondent Monterey also required that all proposers "agree to accept assignment from Medicare and Medi-Cal." App. D, p. 30a. "Medi-Cal" is the State of California's version of the federal/state Medicaid program for eligible indigent patients.

In April 1995, Medicare reimbursement was $459.73 for ALS emergency transport, $8.71 per mile for ALS transport and $32.60 for ALS oxygen. Medicines used were billed separately. App. G, p. 41a-42a. Medicare beneficiaries are required to pay 20% of the approved amounts, either out of pocket or through supplementary insurance.

The relevant Medi-Cal statutes appear to mandate the state department of health reimburse for ALS services using "reasonable cost standards of the department". *Calif. Welfare & Institutions Code* § 14106.6, § 14132. However, since enactment of those statutes in 1980, the state department of health has resisted enacting ALS reimbursement standards and did not do so.

Therefore, respondent Monterey required the provision of the more costly ALS ambulance services to Medi-Cal patients, knowing the state pays only for Basic Life Support ("BLS") ambulance services. "Basic Life Support" personnel have qualifications to perform emergency first aid and to start cardiopulmonary resuscitation but may not use invasive techniques. *Calif. Health & Safety Code* § 1797.60.

To accept Medi-Cal assignment means an agreement to accept the state's BLS reimbursement rates as payment in full for ALS services. The Medi-Cal client pays nothing and the state reimburses $71.59 for ambulance transportation with an additional $9.88 for an "emergency run". The state pays only $3.18 per mile for BLS transport and $9.88 for the administration of oxygen. Since the administration of medicines is not within the scope of practice of BLS personnel, drugs used by paramedics on Medi-Cal clients are free to the state and the patient. App. C, p. 27a.

Respondent Monterey did not disclose the reimbursement standard for county Medically Indigent Adults ("MIA") patients receiving ALS services. Its previous ALS reimbursement standards were based upon the Medi-Cal BLS schedule.

Petitioners filed their responsive bid on July 10, 1995, aware that the state legislature intended that local governments subsidize the provision of paramedic services to indigents:

> The Legislature finds and declares that local governments are subsidizing the provision of paramedic services to indigents, including recipients eligible for the Medi-Cal program. Currently, the Medi-Cal program fails to make reimbursement for the provision of paramedic services, resulting in increased costs to local government. To the degree that paramedic services are provided to persons eligible for the Medi-Cal program, the state and federal government should pay for these services, and the director should make reasonable reimbursement.

Stats, 1980 Chapter 1322, Section 1.

Petitioners' offer took into account that no such reimbursement had been authorized by the state department of health.

Two other organizations filed bids, respondent Peninsula Paramedics, Inc. ("Pen Med"), and Carmel Regional Fire Authority ("CRFA"), a public entity formed to provide ambulance services.

The proposals were reviewed by a proposal review committee and the Monterey County Director of Health. App. D, p. 28a. The proposal review committee was composed of five industry experts who, in turn, were advised on financial matters by (1) the assistant auditor-controller of Monterey County and (2) a nationally recognized financial consulting firm to public entities. App. E, p. 31a, 33a-35a.

Petitioners' offer disallows discounts to respondent Monterey for ALS emergency ambulance services to indigent patients. Under petitioners' cost and charge structure, all other insured patients, including Medicare, incurred lowered ALS base charges. The industry expert committee admitted that it was "not consistent with industry standards." App. E, p. 32a. On the other hand, the committee recommended respondent Pen Med's proposal because, *inter alia*, of its "willingness to accept assignment". App. E, p. 31a-32a.

Petitioners' offer also elicited the admission directly from respondent Monterey that the indigent programs pay "only a small portion of the total charge" for transportation of Medi-Cal and MIA patients:

> A-1's charge structure also includes a proposal that, for all Medi-Cal and medically indigent adult patients, the County should pay the difference between the Medi-Cal and MCMSP reimbursement and the normal ALS charge that would have applied to the transport. The current Medi-Cal and MCMSP rates for ambulance transports pay only a small portion of the total charge. This would result in a very high subsidy for these transports under A-1's proposal.

App. F, p. 36a.

Respondent Monterey further admitted that proposers were expected to overcharge Medicare to make up for the lower charges which respondent Monterey paid for ALS services to indigent patients:

> In addition, A-1 sets an extremely low ALS base rate. In all cases, the A-1 base rate would be lower than the approved Medicare rate. As a result, for these transports, Medicare would pay the lower rate, A-1 would not collect the maximum possible from Medicare, and the effect would be to pass off to the county the difference, in the form of the subsidy paid by the county to A-1 in lieu of the higher collection from Medicare.

App. F, p. 37a.

Respondent Monterey warned earlier in its RFP that "[c]harges that are below the Medicare 'prevailing' charges will be carefully scrutinized". App. D, p. 29a.

Respondents Monterey and Pen Med executed their agreement in September 1995. Petitioners filed their complaint under seal on January 22, 1996, twenty-two days after respondents Pen Med and Monterey's agreement became operative.

Respondents San Mateo and Baystar, and several other defendants were included based upon petitioners' acquisition of financial data for ambulance services from various counties' emergency ambulance RFP's.

Petitioners served the Attorney General with the Complaint and relevant documentary information pursuant

to 31 U.S.C. § 3730(b)(2). A year later, the United States declined to intervene. The Government requested that all pleadings be served on it and that only the Complaint, the notice of declining to intervene and the order be unsealed. The Government made no other motion.

On March 6, 1997, petitioners filed their amended complaint naming only the current respondents. Count One against respondents San Mateo and Baystar (since 1991) and Count Three against respondents Monterey and Pen Med (since 1996) allege that under color of state law and by agreement with respondent counties, the respondent ambulance companies submitted unlawful bills for emergency ambulance services at the ALS level to Medicare beneficiaries which were eventually paid by the United States. Fourteenth Amendment standards of pricing applied because the citizens were subject to maximum rates for emergency ambulance services by private ambulance corporations enacted by local governments, and because citizens had no choice in the level of services for which they were required to use and pay. The constitutional and statutory bases for these allegations are set forth in "A-1 Ambulance's Prior Petition".

Count Two against respondents San Mateo and Baystar and Count Four against respondents Monterey and Pen Med allege that under the respective exclusive franchise agreements, the respondent counties were referring Medicare patients to respondent ambulance companies in exchange for free or discounted ALS services and medications to county responsible patients in violation of 42 U.S.C. § 1320a-7b(b). But, in addition, the charges to Medicare patients, eventually paid by the United States, were inflated to more than cover the costs of services to state and county responsible patients and were constitutionally exorbitant.

Count Five against respondent Pen Med alleged that respondent corrupted the means by which Medicare determined the prevailing ALS charges. The bills for Medi-Cal and MIA patients reflected the county-set charges for ALS services to the public. However, the ALS charges appearing on the bills were not legally enforceable against respondent Monterey because of respondents' prior agreement that ALS services to indigent patients would be reimbursed at BLS rates. Therefore, the ALS charges appearing on the indigents' bills when Medicare surveyed bills to determine the prevailing rates in a service area did not reflect the agreed-to ALS rates, which were zero.

In May 1997, the ambulance defendants below filed a motion to dismiss on public disclosure grounds, submitting approximately 1800 pages of public records to the court. No financial records of either respondent ambulance company for the period of the fraud alleged in the First Amended Complaint were included. The county defendants below joined the ambulance defendants' motion.

On August 8, 1997, the district court granted defendants' motion to dismiss pursuant to 31 U.S.C. § 3730(e)(4) on grounds that petitioners' complaint was based upon publicly disclosed allegations and transactions, because the contracts between the defendants "are all a matter of public record." App. B, p. 24a. The district court rejected petitioners' argument that the allegations and transactions must be in possession of the government prior to relators' filing of the case in order for the public disclosure bar to apply. The district court denied the applicability of this Court's intervening decision in *Hughes Aircraft Company v. United States ex rel. Schumer*, 520 U.S. 939 (1997). App. B, 25a.

The district court also held that petitioners could not contend that they could avail themselves of the original source rule because they were not the "original sources of the transactions at issue". App. B, p. 26a. Moreover, petitioners do not have "direct and independent knowledge of the information on which the allegations were based" because "they do not work for Defendant service providers." App. B, p. 26a.

Shortly thereafter, there occurred a number of paradigmatic public disclosures through the TV and print media of Federal government investigations of ambulance overpayments. There was not one mention of petitioners' allegations concerning cost-shifting, exorbitant profits or local governments as conspirators in the draft government reports. On July 24, 1997, Robert Hager of NBC Nightly News reported:

> Government investigators say Medicare is paying too much for ambulances — a quarter billion dollars a year too much because of outdated billing codes that permit overcharging and are vulnerable to fraud.

On November 9, 1997, Robert Pear of the New York Times reported that,

> Federal investigators, having documented many instances of over-billing and false claims by ambulance operators, say that Medicare wastes hundreds of millions of dollars a year by paying for unnecessary ambulance services provided to elderly patients. . . .

> Federal investigators have repeatedly described the problems in confidential reports to top Medicare officials in the past three years. The Government has increased audits of ambulance companies, but a Medicare official conceded that "we have no way of insuring that we are paying properly for the services."

During this period, petitioners received a message from the California Ambulance Association ("CAA"), an ambulance trade organization. The message stated, *inter alia*,

> Thus far, the governor and Legislature have been unwilling to give us an equitable increase in Medi-Cal funding.
>
> Managed care is poised to rake over the utilization of ambulance services, thereby dealing a major blow to our ability **to shift costs for the uninsured and fixed — fee payers to health plans**. (Emphasis provided)
>
> "Chairman's message", CAA Siren, July-September 1997 at p. 4.

In respondent Monterey's July 8, 1998 brief to the court below in this action at fn. 5, page 22, respondent admitted the following:

> Whether rates to other customers are "increased" or are initially set high enough to cover the costs of indigent transports is immaterial. The point is that the other customers are paying more than they otherwise pay, because of the unavoidable indigent transports.

On February 7, 2000, the Court of Appeals affirmed the district court's dismissal on public disclosure grounds. The court below held that respondent counties' public processes for contracting with respondent emergency ambulance providers, met the requirements of public disclosures of allegations and transactions in administrative hearings within the meaning of 31 U.S.C. § 3730(e)(4)(A). App. A, pp. 8a-12a. The court below indirectly rejected petitioners' argument that the federal government must first possess the information before the public disclosure bar comes into play, by holding that the text of the public fora described contained no federal limitation. "We will not add a term to the statute that Congress elected not to include." App. A, p. 11a.

The court below also held that petitioners' expertise plays no role in removing the jurisdictional bar, because petitioners' claim merely "repeats what the public already knows." App. A, p. 14a.

REASONS FOR GRANTING THE WRIT

Preliminary Statement

While the court below characterizes petitioners' bid for the County of Monterey emergency ambulance franchise as "unsuccessful", App. A, p. 3a, in fact, as a privately executed sting operation on behalf of Medicare beneficiaries, it was quite successful.

The Inspectors General have long complained about the high price of ALS ambulance services. However, her concern about upcoding in the draft report only addresses specific events of providing "unnecessary care", the high price of

ALS ambulance service remains. Petitioners show that Medicare beneficiaries were and still are unwittingly financing ALS services to indigent patients who, by definition, are not eligible for Medicare benefits. Petitioners elicited the "industry standard" admission by submitting an offer which did not offer a discount to respondent Monterey for ALS services to its patients. App. E, p. 32. The "industry standard" is confirmed by the CAA exhorting its membership to fight a major blow to the industry's ability to "shift costs for the uninsured and fixed — fee payers to health plans." CAA Siren, July — September 1997 at p. 4.

Petitioners, through its offer that all patients and/or their insurers pay the same amount for the same services, demonstrate that respondent counties are not innocent recipients of the ambulance industry's largesse, by eliciting admissions that respondent Monterey expected the proposers to overcharge Medicare beneficiaries to relieve respondent counties of their indigent care costs. App. F, p. 37a. Respondent Monterey formally admitted as much to the court below:

> The point is that the other customers are paying more than they otherwise pay, because of the unavoidable indigent transports.

Monterey County Court of Appeals Brief at fn. 5, p. 22.

Petitioners' offer created the opportunity for respondent Monterey to make a choice: go for the proposal that offers a discount for itself and permits respondent Pen Med to charge constitutionally exorbitant rates or for the proposal that requires it to pay the same as Medicare beneficiaries for the same services. Respondent Monterey voluntarily chose the former.

While the court below states that petitioners only repeat what the "public" already knows, to the extent that the "public" in Monterey County other than respondents know anything incriminating, it was a result of the efforts of petitioners at great risk to A-1 Ambulance Service's corporate survival. Moreover, the public admissions go to proof of the creation of the conspiracy, not to the overt acts of submitting false claims because no false claims were submitted to the United States under the challenged agreements until after January 1, 1996 in Monterey County or January 1, 1991 in San Mateo County.

I. THE COURT OF APPEALS' DECISION CONFLICTS WITH A PRIOR DECISION OF THIS COURT.

Review by this Court is warranted because the Court of Appeals' decision conflicts with this Court's decision in *Hughes Aircraft Co. v. United States ex rel. Schumer*, 520 U.S. 939, 117 S. Ct. 1871(1997). In *Hughes*, this Court considered the question of whether or not relator Schumer's pre-1986 claim was jurisdictionally excluded because the information on which it was based was already in the Government's possession. This Court necessarily construed the 1986 Amendments to determine their retroactivity. In so doing this Court construed the statute to say that "public disclosure" was an exception which applied when the relator's suit is based on information in the Government's possession:

> Congress amended the FCA in 1986, however, to permit *qui tam* suits based on information in the Government's possession, except where the suit was based on information that had been

> publicly disclosed and was not brought by an original source of the information. See 31 U.S.C. § 3730(e)(4)(A).

Hughes Aircraft Company, v. United States, ex rel. William J. Schumer, 520 U.S. at 946, 117 S. Ct. at 1876.

Using standard grammatical analysis, the "suit" which is excepted in the phrase "except where the suit was based" is a member of the set of "*qui tam* suits based on information in the Government's possession." Since suits not based upon information in the Government's possession were already permitted, these types of suits could not be newly permitted by Congress and the exception of "public disclosure" can not be addressed to these cases.

Not only did this Court say in plain terms what the statute meant, the subsequent analysis follows this straight forward language to determine whether Congress created new causes of action or eliminated prior defenses for the retroactivity analysis.

> . . . , the 1986 amendment eliminates a defense to a qui tam suit — prior disclosure to the Government — and therefore changes the substance of the existing cause of action for qui tam defendants by attaching a new disability, in respect to transactions or considerations already past.

[Citations and internal quote marks removed.] *Hughes Aircraft Company, v. United States, ex rel. William J. Schumer*, 520 U.S. at 948, 117 S. Ct. at 1877.

According to the courts below, Congress created a new defense without regard to prior disclosure to government. This position is not tenable under this Court's analysis.

The court below also stands the objection to the results of this Court's decision in *U.S. ex rel. Marcus v. Hess*, 317 U.S. 537 (1943) on its head. In that case, contractors collusively bid for a local government contract, funded by the United States. The Government indicted the contractors who were fined after pleading *nolo contendere*. The Government argued that relator Marcus should not have been permitted to prosecute the *qui tam* case because, it alleged, the relator received his information from the indictment and did not contribute to the discovery of the crime. Relator Marcus was a stranger to the underlying fraud as well as to the investigation. The Government argued that permission to outsiders to sue might bring "unseemly races for the opportunity of profiting from the *government's investigations*." (emphasis provided) *Marcus v. Hess*, 317 U.S. at 547. The government did **not** complain that relator Marcus obtained his information from the "administrative hearings" awarding the contract to the collusive bidder.

Here, as in *Marcus*, the contract was a rigged local public contract. But petitioners were not strangers to this bidding, but participants. Here, petitioners elicited information from the contractors which, when coupled with petitioners' expertise, demonstrate that the bid was rigged so that the winning bidder could profit while providing free ALS ambulance services to indigent patients by overcharging the insured patients. In filing this action, petitioners could not profit from the *government's investigation* because whatever the government had in way of an investigation, if any, was not public.

That Congress did not use the word "federal" in the statute does not mean that Congress intended that publications in any forum whatsoever would trigger the bar. The alternative explanation is that neither Congress nor the Government thought that the disclosures were anything other than disclosures of information already in the Government's hands, because Congress and the Government were concerned about "parasitic' suits. Both proponents and opponents of the 1986 False Claims Act amendments considered a "parasitic" suit to be a private suit based upon disclosure(s) of government investigations:

> Another serious problem is posed by the provision permitting a relator to bring an action **based on evidence available to the government**, and to proceed with the action even where the Justice Department chooses not to enter the suit. The Act currently forbids such "**parasitic**" actions by 'bounty hunters' and, in fact, was amended by Congress in 1943 to address just this problem" (emphasis provided) Jay Stephens, deputy attorney general, Senate False Claims Reform Act Hearings, September 17, 1985 ("FCA hearings") at p. 42.
>
> Under the proposed language, if a person bases a lawsuit on information or evidence that the Government has already disclosed in a prior administrative, civil, or criminal proceeding, the person's suit is to be dismissed.

John Phillips, FCA hearings at 96.

Therefore, as between Congress and the Government, there was no requirement to indicate "federal" fora.

By not following this Court's construction in *Hughes*, the court below impermissibly re-weighs the balancing of interests which Congress performed while considering the situations in which defendants come clean before the filing of a False Claims or other action. In one of the last amendments to S. 1562, Congress provided defendants with the possibilities of lesser penalties, not dismissal, if defendants report the fraud themselves. Senator Grassley explained to Senator Hatch on the floor of the Senate as follows:

> Similarly, a procedure is established for corporations to come forward when they discover fraud within their midst. When corporations follow these procedures in cooperating with the Government, the court may impose not only the lesser level of damages, but also a lesser level of penalty.

132 Cong. Rec. 28581. Oct. 3, 1986.

Respondents had and continue to have a duty to **report** fraud to the government, not just talk out loud among themselves about it.[1]

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1. See for example, *www.os.dhhs.gov/progorg/oei/hotline/hhshot.html:* "All HHS and contractor employees have a responsibility to assist in combating fraud . . . As such you are encouraged to **report** matters involving fraud . . . to the OIG. To assist you, the OIG maintains a hotline which offers a confidential means for **reporting** vital information."(emphasis provided).

II. ASIDE FROM THIS COURT IN *HUGHES*, 31 U.S.C. § 3730(e)(4) HAS BEEN CONSTRUED WITHOUT THE PARTICIPATION OR GUIDANCE OF THE UNITED STATES LEADING TO CONFLICTING CONCLUSIONS BELOW.

Review by this Court is also warranted because it is the only way the views of the Government on the meaning of 31 U.S.C. § 3730(e)(4) may be obtained. After oral argument in the court below, petitioners learned that the principal sponsors of the 1986 False Claims Act Amendments had noted in a letter to the Attorney General that the Department of Justice ("DOJ") has been silent whenever the public disclosure issue has been litigated in the courts below. Extension of Remarks of Mr. Berman, 145 Cong. Rec. E1546, 1547-1548 (July 14, 1999). The Attorney General was silent in this case as well.

Yet, the record reveals that DOJ was actively involved in the passage of the 1986 False Claims amendments, by testimony and negotiation with congressional staff. The government's interest in the *qui tam* sections was specifically identified:

> As stated in our previous testimony, the Department does not believe that any changes are necessary in the "*qui tam*," or citizen suit, portions of the False Claims Act. However, the current language of S. 1562, a result of negotiations between representatives of the Department and subcommittee staff, is not objectionable in the context of the bill's other beneficial amendments to the False Claims Act.

Letter of Phillip D. Brady, Acting Assistant Attorney General, 132 Cong. Rec. 5266, 5301 (1986).

Clearly, *qui tam* plaintiffs were not privy to the negotiations between DOJ and Congress and can not represent authoritatively to the courts below what the Government understood the "current" language meant. See for an example of the issue, *U.S. ex rel. Mistick v. Housing Authority of the City of Pittsburgh*, 186 F.3d 376, 387 (3rd Cir. 1999), where after discussing at length whether it should use interpretations based on the ordinary meaning of the phrase 'based upon' and one based on the precept that a statute should be construed if possible so as not to render any of its terms superfluous, the court finds that "[t]he inescapable conclusion is that the qui tam provision does not reflect careful drafting." The right party was not before the court to explain the intent of the drafting, however unclear the text.

However, the views of the Government on 31 U.S.C. § 3730(e)(4) were extensively expressed before this Court in *Hughes*. Had the Government made known those views years earlier (and since) to relators and the courts below, uncounted hours of litigation on the public disclosure issue would have been avoided, permitting *qui tam* plaintiffs to focus on the merits of the claims for the benefit of the United States[2] as well as themselves. The conflicts among the circuits is reviewed in *U.S. ex rel Mistick, supra*.

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2. Proving the merits in this case is not exotic, because only a financial audit is required. As indicated by this Court over 50 years ago, the establishment of a rate for a regulated industry involves two steps, the adjustment of the general revenue to the demands of a fair return and adjustment of a rate schedule conforming to that (Cont'd)

III. THE GOVERNMENT'S POSITION IN *HUGHES* MANDATES GOVERNMENTAL POSSESSION OF INFORMATION AS A CONDITION PRECEDENT TO THE APPLICATION OF THE PUBLIC DISCLOSURE BAR.

In its *amicus* brief in *Hughes*, the Government recognized that the public disclosure bar is to protect the Treasury from deprivation in the amount of *the relator's share* when it is shown that the government is taking action or capable of taking action:

> In the circumstances specified in the statute — particularly where there has been a public disclosure through specified types of government reports and actions — it is likely that the government is already investigating the matter, or appropriate government investigatory personnel have sufficient information to trigger an investigation. Unless the relator is an "original source," qui tam lawsuits brought in these circumstances — after a public disclosure has occurred showing that the government is itself taking action or is capable of taking action — are likely to bring the Treasury nothing more than what government prosecutors would have

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(Cont'd)
level so as to eliminate discrimination and unfairness. *Federal Power Commission v. Natural Gas Pipeline*, 315 U.S. 575, 584 (1942). Proof of exorbitant profits and discrimination in the allocation of direct and indirect costs is merely to reverse the process. Even mom and pop ambulance services such as A-1 Ambulance can perform these calculations upon request.

> recovered on their own initiative, and they divert a portion of that recovery unnecessarily from the Treasury to private hands.

Brief of the United States as Amicus, *Hughes Aircraft v. U.S. ex rel. Schumer* fn. 12, p. 19.

Nothing in respondents' claimed disclosures remotely suggest that the United States was in a position to bring to the Treasury any more money on its own in this case. The Government's election not to dismiss this case on any ground should have ended the inquiry. Nonetheless, the court below is in error because the government must possess some information to investigate before a public disclosure can occur.

IV. THE GOVERNMENT'S POSITION IN *HUGHES* MANDATES ONCE THE GOVERNMENT DECLINES TO DISMISS THE CASE, PUBLIC DISCLOSURE LITIGATION IS OVER.

The Government's position in *Hughes* exposes defendants' motion to dismiss on "public disclosure" grounds to be a legal oxymoron[3]. If the United States can not bring a motion to dismiss on its own by identifying a public disclosure which if prosecuted by Government would save the Treasury the loss of relator's share, then there is no evidentiary basis for the defendants to move for dismissal on the same grounds. Respondents' beef would be with DOJ, not petitioners.

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3. Defendants move to dismiss on public disclosure grounds to save the Treasury from deprivation of relator's share(??)

Moreover, the events surrounding this particular action show that it is the Government which is in control of the evidence which would permit *qui tam* plaintiffs to go forward. The Government could not move to dismiss petitioners' action herein when filed because, as was disclosed later in the media, the Government had plenty of "allegations and transactions" on ambulance overpricing in its possession, but those allegations and transactions were based upon an entirely different theory of liability from that of petitioners. Of course, those allegations and transactions weren't published until after petitioners' filing.

V. THE QUESTIONS PRESENTED ARE IMPORTANT.

The issues in this case are important because the United States needs help in combating Medicare ambulance overcharging. Specifically, the United States needs help in auditing ambulance providers. The United States has said as much: "The Government has increased audits of ambulance companies, but a Medicare official conceded that 'we have no way of insuring that we are paying properly for the services' ". Pear, New York Times November 9, 1997.

The very purpose of the 1986 False Claims Act is to provide additional resources to the United States in combating fraud. S. Rep. 99-345,132 Cong. Rec. 5266, 5272 (1986). By filing suit, petitioners offer those additional resources. Respectfully, petitioners are in a better position than federal agencies are to litigate this suit, because of petitioners' familiarity with applicable state laws concerning, *inter alia*, state reimbursement for indigent services and, indeed, petitioners' intimate knowledge of the billing process itself. The United States did not object to petitioners providing those resources in this case.

The questions are important because of the magnitude of the financing of indigent services by Medicare and Medicare beneficiaries. Data from the County of Alameda, California, which operates under the same indigent cost-shifting scheme as respondent counties do show that in 1996, while Medicare patients comprised 24% of the ambulance transports, Medicare and Medicare beneficiaries paid 41% of the total revenue, a premium of 71%. In contrast, Medi-Cal patients comprised 26% of the transports and only provided 10% of the revenue.

Respondent San Mateo provides an elegant example of how the indigent support is achieved. Respondent San Mateo simply finds out what percent was collected and then adds the uncollected amount to the costs of drugs and supplies in the bills to insured patients to cover cost of the drugs and supplies used in indigent patients for which respondent San Mateo pays nothing. Respondent San Mateo inflated the drug and supply bill by about 44%.

The OIG-HHS July 1997 draft report "Medicare Ambulance Payments" OEI-05-00300, states that in 1995, carriers paid two billion dollars to ambulance providers. An absolute amount of the support by Medicare of indigent services can not be determined from these data because details were not published by the OIG. But with that total amount of $2 billion dollars per year in play, indigent support by Medicare and Medicare beneficiaries is not insignificant.

Finally, the Court's attention is respectfully directed to the fact that this litigation does not concern the ordinary government — contractor relationship, but rather it concerns an insurance program in which elderly beneficiaries must pay premiums to be eligible for benefits and must pay a 20%

co-payment with each service. Petitioners were intimately involved in billing and collecting those amounts. Federal agencies may not be quite as aware as petitioners are of the unfairness experienced and financial hardships incurred by the elderly when required to pay unwittingly about 44% more because of services rendered to others.

CONCLUSION

For the reasons stated above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT DATED AND FILED FEBRUARY 7, 2000

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 98-15200

D.C. No. CV-96-20048-JW

A-1 AMBULANCE SERVICE, INC., a corporation, aka Seal 1; DENNIS B. BARRETT, an individual,

Plaintiffs-Appellants,

v.

STATE OF CALIFORNIA, a political subdivision, aka Seal A; DANIEL SMILEY, Deputy Director, California State Emergency Medical Services Authority; THE COUNTY OF FRESNO; K W P H ENTERPRISES, dba American Medical Services; SAM KARAS; TOM PERKINS; BRIAN SINNOTT,

Defendants,

and

COUNTY OF SAN MATEO; MED-TRANS, dba Hartson Medical Services, dba Baystar; COUNTY OF MONTEREY, a political subdivision; PENINSULA PARAMEDIC SERVICES, INC., a corporation,

Defendants-Appellees.

Appendix A

OPINION

Appeal from the United States District Court
for the Northern District of California
James Ware, District Judge, Presiding

Argued and Submitted
August 5, 1999 — Pasadena, California

Filed February 7, 2000

Before: Alex Kozinski and Sidney R. Thomas,
Circuit Judges, and Johnnie B. Rawlinson,[1] District Judge.

Opinion by Judge Thomas

* * *

OPINION

THOMAS, Circuit Judge:

A-1 Ambulance Service, Inc. ("A-1") appeals the district court's dismissal of its *qui tam* action against the County of San Mateo, the County of Monterey, and two private ambulance companies for alleged violations of the False Claims Act, 31 U.S.C. §§ 3729-3733. The district court dismissed A-1's action for lack of subject matter jurisdiction under the "public disclosure bar" of 31 U.S.C. § 3730(e)(4)(A)

1. The Honorable Johnnie B. Rawlinson, United States District Judge for the District of Nevada, sitting by designation.

because A-1's action was based upon information publicly disclosed in local government administrative hearings. We have jurisdiction under 28 U.S.C. § 1291, and we affirm.

I

A-1 was an unsuccessful bidder for public contracts to provide exclusive ambulance services within certain California counties, including San Mateo and Monterey Counties (the "Counties"). Med-Trans and Peninsula Paramedic Services, Inc. ("Pen-Med") are the two private ambulance service providers that were awarded those exclusive contracts in San Mateo and Monterey Counties respectively. In its *qui tam* action, A-1 essentially alleges that the Counties, together with Med-Trans and Pen-Med, conspired to shift some of the costs of emergency ambulance services from the Counties to Medicare in violation of the anti-kickback provisions of the Medicare Act, 42 U.S.C. § 1320a-7b(b). To fully understand A-1's claim, however, some background information is required.

In California, pre-hospital emergency medical services ("EMS"), such as ambulance and paramedic services, are regulated by the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act ("EMS Act"). *See* Cal. Health & Safety Code §§ 1797-1799.201 (West 1990 & Supp. 1999). Under the EMS Act, individual counties are authorized to designate local EMS agencies to administer emergency medical services programs within their respective jurisdictions. The EMS agencies are required to develop and administer a plan for providing emergency medical services to all of its county's residents, including

ambulance services for the indigent population. Both Counties in this case designated their respective health departments as their local EMS agencies.

Pursuant to the EMS Act, each EMS agency may create one or more exclusive operating areas within its county for the delivery of emergency ambulance services. *See id.* §§ 1797.85, 1797.224. The exclusive operating area contracts are awarded through a competitive bidding process in which the EMS agencies solicit bids from prospective ambulance service providers. The invitation for bids is commonly referred to as a Request for Proposal ("RFP"). The selection process requires several rounds of public administrative hearings, beginning with the dissemination of an RFP for public review and comment, and concluding with the actual selection of an EMS provider by each county's governing body, the Board of Supervisors. As they were legally required to do, both Counties utilized this competitive bidding process to select their respective EMS providers.

A

Beginning in 1994, Monterey County initiated efforts to redesign its EMS program. Between September and December of that year, Monterey County's four Regional Councils, which were advisory committees to Monterey County's EMS agency, conducted several public meetings to discuss draft RFPs. The Monterey County Board of Supervisors then considered these RFPs on December 6, 1994, at a public meeting attended by, among others, A-1. After holding additional hearings and receiving public comment, the Board approved a final RFP in March of 1995.

Appendix A

The final RFP, which became part of the official public record, provided for a single countywide exclusive operating area and described the primary terms and conditions of the ambulance service contract to be awarded, including the types and amounts of charges permitted to Medicare and other third-party payors. The final RFP also requested that bidders propose the amount of subsidy they believed they would require to cover the costs of non-chargeable or uncollectible ambulance services. After publicly noticing and circulating the final RFP, Monterey County held a bidders conference on April 19, 1995. At the public conference, potential bidders raised the issue of Medicare reimbursement and whether it would be sufficient at the maximum allowable rates specified in Monterey County's RFP. After the conference, three EMS providers, including A-1 and Pen-Med, responded to Monterey County's RFP.

Thereafter, a bid review committee recommended the selection of Pen-Med as Monterey County's EMS provider. The Board accepted the recommendation and ratified the contract with Pen-Med in two separate public hearings held in September of 1995. At both those hearings, the Board discussed the issues of Medicare reimbursement and a subsidy for uncollectible ambulance services. Ultimately, Monterey County agreed to provide a $450,000 subsidy to Pen-Med to help defray the costs of non-chargeable and uncollectible ambulance services.

B

San Mateo County began searching for a new EMS provider in 1990. In March of that year, the director of San

Mateo County's EMS agency sent a proposed draft RFP to the Board of Supervisors. The proposed RFP stated that ambulance services would be supported by user fees only, without any county subsidy. It also set the maximum rates that the selected EMS provider would be permitted to bill Medicare and other third-party payors. The Board convened a public hearing on March 27, 1990, to consider the draft RFP. It approved the RFP, which became part of the official public record, and released it to the public for review and comment.

On May 9, 1990, San Mateo County conducted a public bidders conference. At the conference, San Mateo County representatives were asked whether San Mateo County would reimburse the costs of ambulance services for indigent patients. The San Mateo County officials indicated that there would be no reimbursement. On July 3, 1990, three ambulance companies submitted proposals to the RFP. The proposals were evaluated by a review committee and then discussed at three separate public Board meetings. The Board ultimately selected Med-Trans as its EMS provider, and the contract with Med-Trans was made part of the public record. Like the RFP, the contract stated that San Mateo County was providing no subsidy for any of the ambulance services rendered by Med-Trans.

C

A-1 alleges that the Counties' ambulance service contracts perpetrate a fraud upon the federal government in violation of the False Claims Act. In a nutshell, A-1 contends that the costs of providing ambulance services to

county-responsible indigents are unlawfully shifted from the Counties to private and third-party payors, including the federal Medicare program. Such unlawful cost-shifting occurs, A-1 argues, because the Counties' ambulance service contracts offer little or no subsidy to cover the costs of ambulance services for their indigent populations. According to A-1, therefore, Med-Trans and Pen-Med are forced to charge artificially inflated rates to Medicare- covered patients in order to offset the losses incurred when rendering ambulance services to indigent patients. As a result, A-1 claims that the Counties' ambulance service contracts effectively compel the federal government, in violation of the Medicare Act, to subsidize ambulance services at "exorbitant" rates for indigent patients who are otherwise ineligible for Medicare benefits.

The district court concluded that the False Claims Act's public disclosure bar deprived it of jurisdiction, and granted the Counties' motion to dismiss. We review that decision *de novo*. *See United States ex rel. Aflatooni v. Kitsap Physicians Servs.*, 163 F.3d 516, 520 (9th Cir. 1999). We review the district court's findings of fact relevant to its determination of subject matter jurisdiction for clear error. *See United States ex rel. Biddle v. Board of Trustees of Leland Stanford, Jr. Univ.*, 161 F.3d 533, 535 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1457 (1999). The question of whether a particular disclosure triggers the jurisdictional bar of § 3730(e)(4)(A) is a mixed question of law and fact, which we review *de novo*. *See United States ex rel. Lindenthal v. General Dynamics Corp.*, 61 F.3d 1402, 1409 n.9 (9th Cir. 1995).

Appendix A

II

The False Claims Act deprives a district court of jurisdiction over any *qui tam* action that is based upon allegations or transactions already disclosed in certain public fora, unless the relator is the original source of the information underlying the action. The relevant section, 31 U.S.C. § 3730(e)(4)(A), provides:

> No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

The public disclosure bar contained in § 3730(e)(4)(A) sets up a two-tiered inquiry. First, we must determine whether there has been a prior "public disclosure" of the "allegations or transactions" underlying the *qui tam* suit. *See United States v. Alcan Elec. & Eng'g, Inc.*, 197 F.3d 1014, 1018 (9th Cir. 1999). If and only if there has been such a public disclosure, we next must inquire whether the relator is an "original source" within the meaning of § 3730(e)(4)(B). *See id.* Because A-1 neither qualifies as nor alleges to be an "original source," the dispositive question presented on appeal is whether the "allegations or transactions" underlying A-1's fraud claim have been "publicly disclosed."

Appendix A

The public disclosure question, in turn, requires that we make two distinct but related determinations. First, we must decide whether the public disclosure originated in one of the sources enumerated in the statute. Under § 3730(e)(4)(A), public disclosure can occur in one of three categories of fora: (1) in a "criminal, civil, or administrative hearing," (2) in a "congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation," or (3) in the "news media." 31 U.S.C. § 3730(e)(4)(A).

If there has been public disclosure through one of these sources, we must then determine whether the content of the disclosure consisted of the "allegations or transactions" giving rise to the relator's claim, as opposed to "mere information." *Hagood v. Sonoma County Water Agency*, 81 F.3d 1465, 1473 (9th Cir. 1996). However, the substance of the disclosure need not contain an explicit "allegation" of fraud; the jurisdictional bar is raised so long as the material elements of the allegedly fraudulent "transaction" are disclosed in the public domain. *See id.* (citing *United States ex rel. Springfield Terminal Ry. v. Quinn*, 14 F.3d 645, 654 (D.C. Cir. 1994)). We conclude that the district court correctly dismissed A-1's suit for lack of jurisdiction because the underlying "transactions" that A-1 claims are fraudulent had already been publicly disclosed in local "administrative hearing[s]."

A

The extensive public agency proceedings conducted by the Counties plainly fall within the ambit of "administrative hearing[s]" under § 3730(e)(4)(A). In the first place, it is

axiomatic that agency actions are inherently "administrative." Thus, we cannot view the official actions of a local EMS agency and its governing entity, the Board of Supervisors, as anything other than "administrative" in nature. Moreover, the numerous public proceedings conducted by these agencies certainly qualify as "hearing[s]" within the meaning of the False Claims Act. "Hearing" in this context is synonymous with "proceeding," *see Springfield Terminal Ry.*, 14 F.3d at 652, and, for purposes of raising the public disclosure bar, encompasses publicly-filed documents, "even if they are not the subject of a hearing." *Alcan Elec. & Eng'g, Inc.*, 197 F.3d. at 1020; *accord Hagood*, 81 F.3d at 1474 n.13 ("That documents filed with an agency or court during administrative proceedings or civil litigation are considered publicly disclosed is a firmly established principle.").

In this case, public disclosure through administrative hearings was deliberate and not incidental. In fact, public disclosure was unavoidable because the competitive bidding process used to award exclusive operating area contracts necessarily entailed several public administrative proceedings, beginning with the public dissemination of RFPs and concluding with the selection of an EMS provider by each County's Board of Supervisors. Furthermore, as required by California law, these agency proceedings were made open to public attendance and actually invited, as well as received, public comment. In addition, all documents relevant to these agency proceedings were openly distributed and made part of the official public record. Thus, in light of the numerous agency proceedings held by the Counties and the inherently public nature of the bidding process, we are compelled to conclude that public disclosure occurred in this case through administrative hearings.

In so holding, we necessarily reject A-1's cramped view of what constitutes an "administrative hearing" for purposes of applying the public disclosure bar. According to A-1, an administrative hearing within the meaning of § 3730(e)(4)(A) is confined to a "proceeding at which issues of fact concerning fraud are investigated and resolved while evidence, either in documentary or oral form, is presented." Nothing in the text of § 3730(e)(4)(A), however, demands such a crabbed interpretation. Indeed, the provision provides no basis for concluding that local government agency proceedings, such as the ones that took place here, are somehow stripped of their "administrative" nature or deprived of their status as "hearings" just because they may not involve fraud investigations or evidentiary presentations.

We further reject A-1's contention that administrative hearings must be federal in order for the public disclosure bar to apply. The unambiguous text of the first category of public fora described in § 3730(e)(4)(A) does not contain any federal limitation. Congress could have easily limited the public disclosure bar to "*federal* criminal, civil, or administrative hearings," but chose not to do so. If the statutory language is clear, that is the end of our inquiry. *See Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992). We will not add a term to the statute that Congress elected not to include.

United States ex rel. Dunleavy v. County of Delaware, 123 F.3d 734 (3d Cir. 1997), which considered a related issue, is not to the contrary. In that case, the Third Circuit faced the question of whether a report prepared by Delaware County constituted an "administrative report" within the

meaning of § 3730(e)(4)(A). *See id.* at 744. In doing so, the court was required to construe the second category of public fora listed in the statute, that is "a congressional, *administrative*, or Government Accounting Office *report*, hearing, audit, or investigation." The court concluded that the term " 'administrative' when read with the word 'report' refers only to those administrative reports that originate with the federal government." *Id.* at 745. In contrast, this case requires us to interpret a different phrase in the statute, one unadorned with any of the "federal" modifiers that were central to the Third Circuit's analysis in *Dunleavy*. Thus, as a matter of statutory construction, the two questions are far divergent, and *Dunleavy* did not reach the issue confronting us in this case. Indeed, *Dunleavy*'s interpretation buttresses our conclusion because one may presume that Congress acted intentionally in including the modifying language in one clause, but omitting it in another. *See Kim v. United States*, 121 F.3d 1269, 1276 (9th Cir. 1997). It is unlikely that Congress would have referenced administrative hearings twice in the same sentence, unless it intended to allude to different contexts.

For all these reasons, we conclude that the local agency proceedings in this case were "administrative hearings" within the meaning of § 3730(e)(4)(A).

B

The content of the disclosures at the administrative hearings consisted of the essential "transactions" underlying A-1's fraud claim. Contrary to what A-1 suggests, the information publicly disclosed in the local agency

proceedings contained the material facts underlying A-1's allegation of fraud. In the course of the local agency proceedings, there was public disclosure of the following material facts: (1) the amount, if any, of county subsidies under the exclusive operating area contracts, (2) the fact that the Counties would not otherwise be billed for services rendered to indigent patients, (3) the maximum allowable rates that the EMS providers could charge Medicare and other third-party payors, and (4) the issue of whether Medicare reimbursement would be sufficient at the maximum allowable rates specified by the contracts. In short, all the material transactions giving rise to the Counties' allegedly unlawful cost-shifting schemes were publicly disclosed. That the disclosed transactions themselves may not have pointed directly to any wrongdoing is simply of no moment. *See Hagood*, 81 F.3d at 1473-74.

For this reason, we must also reject A-1's contention that its unique knowledge removed the jurisdictional bar. There is no such exception in the statute; the public disclosure bar is triggered by disclosure of "allegations or transactions." 31 U.S.C. § 3730(e)(4)(A). "A relator's ability to recognize the legal consequences of a publicly disclosed fraudulent transaction does not alter the fact that the material elements of the violation already have been publicly disclosed." *United States ex rel. Findley v. FCP-Boron Employees' Club*, 105 F.3d 675, 688 (D.C. Cir. 1996). The mere fact that A-1's own expertise in the area of emergency ambulance services may have enabled it to formulate its novel legal theory of fraud is irrelevant to the question of whether the material transactions giving rise to the alleged fraud were already disclosed in the public domain in the first place. "If a relator—

merely uses his or her unique experience or training to conclude that the material elements already in the public domain constitute a false claim, then a *qui tam* action cannot proceed." *Id.* In sum, "fairly characterized," A-1's claim merely "repeats what the public already knows." *Wang v. FMC Corp.*, 975 F.2d 1412, 1417 (9th Cir. 1992).

III

Because the material transactions underlying A-1's fraud claim were publicly disclosed in local government administrative hearings, the False Claims Act deprived the district court of jurisdiction to hear A-1's *qui tam* action. Accordingly, we affirm the district court's decision dismissing A-1's suit for lack of subject matter jurisdiction.

AFFIRMED

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA GRANTING DEFENDANTS' MOTION TO DISMISS FIRST AMENDED COMPLAINT DATED AUGUST 6, 1997 AND FILED AUGUST 8, 1997

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

Case No. C-96-20048-JW

THE UNITED STATES OF AMERICA, ex rel.
A-1 AMBULANCE SERVICE, INC., et al.,

Plaintiffs,

vs.

THE COUNTY OF SAN MATEO, et al.,

Defendants.

ORDER[1] GRANTING DEFENDANTS' MOTION TO DISMISS FIRST AMENDED COMPLAINT

Defendants MedTrans, Hartson Medical Services, BayStar Medical Services and Peninsula Paramedic Services, Inc.'s ("Defendants") motion to dismiss Plaintiffs' complaint, or, in the alternative, motion for summary judgment was heard by the Court on July 28, 1997. Defendants County of Monterey and County of San Mateo

1. This disposition is not appropriate for publication and may not be cited.

filed joinders to Defendants' motion. Attorney R. Michael Scarano appeared on behalf of the moving Defendants and attorney Eugene Dong appeared on behalf of Plaintiffs. Deputy County Counsel William K. Rentz appeared on behalf of the County of Monterey and Deputy County Counsel Brenda B. Carlson appeared on behalf of the County of San Mateo. Based on all papers filed to date, as well as on the oral argument of counsel, the Court grants Defendants' motion to dismiss this action on the basis that the Court lacks jurisdiction over the subject matter of this case, as discussed below.

I. BACKGROUND

Relators, A-1 Ambulance Service, Inc. and Dennis B. Barrett, A-1's Director of Operations, allege that the Defendants have violated the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, by submitting false claims to the Federal Medicare Program. The core of the Relators' allegations is that Defendants submit false claims to Medicare in order to finance Advanced Life Support ("ALS") or paramedic emergency ambulance services provided to county-responsible indigent patients.

The Emergency Medical Services System and the Prehospital Medical Care Personnel Act (the "EMS Act"), Cal. Health and Safely Code §§ 1797 *et seq.*, governs the delivery of prehospital emergency medical services in California. Under the EMS Act, a County is authorized to designate a local EMS Agency to develop an EMS program in its jurisdiction. Such agency may be the County's own health department. Defendants County of Monterey and

County of San Mateo both designated their own health departments as their EMS agencies.

The EMS agency is responsible for developing and implementing a plan for providing emergency medical services to the County's residents, including emergency ambulance service for all residents, including county indigents. The EMS Act grants each EMS agency the authority to establish exclusive operating areas ("EOAs") in its jurisdiction to one or more ambulance providers. In order to create an EOA, an EMS agency is required to provide a "competitive process" whereby any and all ambulance providers may submit proposals in response to the agency's request for proposals ("RFP"). The proposals are then reviewed by the EMS agency and a special review committee appointed by the agency and a contract is awarded to the successful bidder.

Pursuant to the terms of the Ralph M. Brown Act, Cal. Govt. Code §§ 54950, *et seq.* (the "Brown Act"), all business of the county commissions, boards and councils must be open to the public and persons permitted to attend any meeting. The board is required to post an agenda of each business item at least 72 hours before each meeting and no action can be taken by the board on any item not appearing on the agenda. *Id.*

A. Monterey County

From 1990 to 1995, Monterey County was divided into multiple service areas for the purpose of establishing EOAs. EMS providers Peninsula Paramedic Services, Inc.

("Pen-Med"), A-1 Ambulance and Carmel Regional Fire Ambulance ("CRFA") provided services in these areas. In March of 1995, the County Board of Supervisors, after receiving public comments and holding a public hearing, decided to approve an RFP which provided for a single countywide EOA. The RFP describes the primary terms and conditions of the ambulance contract to be awarded, including the types of charges permitted and allowed to Medicare and other payors. The RFP also requests that the bidder propose the amount of a subsidy it believes it needs from the County to cover non-chargeable or uncollectable ambulance calls.

In April of 1995, the County publicly circulated its RFP. A bidders conference was held on April 19, 1995 and was attended by about 34 people. At the conference, issues were raised about Medicare reimbursements and the appropriate rates which would be charged. EMS providers Pen-Med, A-1 and CRFA responded to the RFP.

After the completion of an evaluation process, a recommendation was made to select Pen-Med as the County's EMS provider. On September 26, 1995, the County Board of Supervisors held a public meeting to consider the approval of the recommendation. The issue of a subsidy for indigents and how that subsidy related to Medicare and Medi-Cal rates was again discussed. The Board approved the contract with Pen-Med and the terms of the contract, including the maximum charges permitted to Medicare and other payors, were made part of the public record. (See Appendix No. 3, Exhibit 24). This contract became effective on January 1, 1996, the date the previous providers' contracts with the County expired.

Appendix B

B. San Mateo County

From 1983 to 1990, Mobile Life Support ("MLS") provided ambulance service to San Mateo County. Pursuant to the terms of its contract, San Mateo did not subsidize ambulance services.

In March of 1990, the San Mateo County Board of Supervisors, after conducting a public hearing and accepting public comment, adopted an RFP. The RFP, which became part of the public record, addresses the maximum rates permitted by the contractor to bill Medicare and other third party payors. The RFP also provides that there is no subsidy and that ambulance services will be supported by user fees.

On May 9, 1990, a proposers conference was held and about 60 people attended. On July 3, 1990, three ambulance companies submitted proposals: (1) National Medical Transportation Network, Inc. dba Hartson Medical Services, Trans-Care, Inc. dba Baystar Medical Services ("Baystar"), MLS and Life Rescue. After evaluation by a review committee, as well as extensive public hearings at three separate Board meetings, the Board approved a contract with Baystar. The contract, which became part of the public record, states that the County is not providing any payment or subsidy for any of the services provided by Baystar. (See Appendix No. 3, Exhibit 42). The contract terms covered the period from January 1, 1991 to December 30, 1995.

Appendix B

C. Relators' Action

In 1996, A-1 sued the EMS providers, as well as the Counties of Monterey and San Mateo, for damages and civil penalties based on alleged violations of the False Claims Act. After the filing of the complaint, the United States was given an opportunity to intervene in this case. On January 22, 1997, the United States declined to intervene. Relators filed a First Amended Complaint on March 6, 1997.

Relators' complaint alleges that the terms of the ambulance service contracts between the Defendants violate the False Claims Act because the providers charge a higher rate to Medicare than they charge to other payors. More specifically, Relators allege that the Monterey and San Mateo County contracts with Pen-Med and BayStar, respectively, authorize Pen-Med and BayStar to bill the public based on one rate schedule but to use a separate schedule of charges published by the State Department of Health for county responsible patients.

The Department of Health Schedule does not provide reimbursement for ALS transportation services, nor does it provide for reimbursement for drugs and medications to County responsible indigent patients. It is Relators' contention that, since Pen-Med and BayStar are not reimbursed for their services and medications provided to County indigent patients, they have conspired with the Counties to charge higher rates to Medicare-covered patients in order to improperly absorb the losses incurred when services are rendered to County responsible indigent patients.

Appendix B

Defendants jointly move to dismiss Realtors' case on the basis that the Court lacks subject matter jurisdiction over this action due to the fact that the transactions on which the First Amended Complaint are based were "publicly disclosed" prior to the filing of the Relators' complaint. Further, Defendants contend that the Relators were not the "original sources" of the transactions alleged in the complaint and cannot, therefore, maintain this action. Defendants' motion is based on Section 3730(e)(4)(A) of the False Claims Act.

Realtors oppose Defendants' motion on the basis that Section 3730(e)(4) does not apply to this action. Even assuming that such Section does apply, Relators argue that there has been no public disclosure of the allegations or transactions which form the basis of their First Amended Complaint.

II. LEGAL STANDARDS

In ruling on a motion to dismiss based on the face of the complaint, the court must accept as true all allegations of material fact and must construe said allegations in the light most favorable to the non-moving party. *Western Reserve Oil & Gas Co. v. New*, 765 F.2d 1428, 1430 (9th Cir. 1985). Any existing ambiguities must be resolved in favor of the pleading. *Walling v. Beverly Enterprises*, 476 F.2d 393, 396 (9th Cir. 1973).

However, these presumptions do not apply when the motion to dismiss is based on extrinsic evidence. *Williamson v. Tucker*, 645 F.2d 404 (5th Cir. 1981). In an instance when

extrinsic evidence is considered pursuant to a Rule 12(b)(1) motion, the court may weigh and determine conflicting facts and the burden of proof is on the plaintiff, the party who invoked jurisdiction, to establish that jurisdiction is proper. *Stock West, Inc. v. Confederated Tribes*, 873 F.2d 1221, 1225 (9th Cir. 1989).

In addition, extrinsic evidence may be considered by the court on a motion to dismiss for failure to state a claim under Rule 12(b)(6), in which case the motion is converted into a motion for summary judgment under Rule 56. Fed. R. Civ. Proc. 12(b)(6). However, matters as to which the court may take judicial notice are not considered to be "outside the pleadings". *Mullis v. United States Bank, Ct.*, 828 F.2d 1385, 1388 (9th Cir. 1987).

A complaint may be dismissed as a matter of law for two reasons: (1) lack of a cognizable legal theory or (2) insufficient facts stated under a cognizable theory. *Robertson v. Dean Witter Reynolds, Inc.*, 749 F.2d 530, 533-34 (9th Cir. 1984). In order to grant a motion to dismiss, it must appear to a certainty that a plaintiff would not be entitled to relief under any set of facts which could be proved. *Wool v. Tandem Computers, Inc.*, 818 F.2d 1433, 1439 (9th Cir. 1987).

Appendix B

III. DISCUSSION

Section 3730(e)(4)(A) of the False Claims Act provides that:

> No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administratives or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

31 U.S.C. § 3730(e)(4)(A).

Defendants contend that the Court lacks jurisdiction over this action on the bases that the "allegations or transactions" were publicly disclosed and that the Relators were not the "original source" of the information alleged in the Complaint. If Defendants' contentions are correct, the case must be dismissed. *See, Hagood v. Sonoma County Water Agency*, 81 F.3d 1465, 1472 (9th Cir. 1996). In order to determine this issue, the Court must examine whether the allegations or transactions alleged in the complaint were publicly disclosed and, if so, whether the Realtors were the "original source" of such disclosure.

Appendix B

A. Public Disclosure

As noted above, the allegations or transactions alleged in Relators' First Amended Complaint contend that the Defendants submit claims to Medicare for reimbursement which are false in that such claims are higher than those claims submitted to other payors for the same services. Defendants' alleged motive for submitting such false claims is that the services provided by Defendants to County indigents are not reimbursed and that, by inflating the Medicare bills, Defendants are able to reimburse themselves for such services and, therefore, avoid sustaining any loss by providing services to indigents.

Defendants argue that all of Relators' "allegations or transactions" as set forth in the First Amended Complaint were publicly disclosed because the contracts between the Defendants are all a matter of public record. Defendants request that the Court take judicial notice of these contracts and the Court grants such request.

Based on its review of the allegations contained in the First Amended Complaint as well as the contracts between the Defendants, the Court finds that the allegations have been publicly disclosed. *See, Hagood v. Sonoma County Water Agency*, 81 F.3d 1465 (9th Cir. 1996). The Court rejects Relators' argument that Section 3730(e)(4) only applies to cases where the information on which the *qui tam* action is based is in the hands of the government prior to the filing of the relators' action. The Court also rejects Relators' argument that the transactions have not been publicly disclosed because the financial records of Defendants must be analyzed in order

to determine whether Defendants' charges to Medicare are constitutionally permissible.

With respect to Relators' argument that, in order for Section 3730(e)(4) to apply, the allegations or transactions must have been in the possession of the government prior to the filing of the relators' action is not supported by the cases cited by Relators. The recent United States Supreme Court case of *Hughes Aircraft Company v. United States ex rel. Schumer*, does not state such a requirement. The *Hughes* case simply decided that the 1986 amendments to the False Claims Act do not apply retroactively. The decision explicitly states that the opinion is not addressing the Ninth Circuit's "public disclosure" analysis.

Similarly, the Court rejects Relators' argument that the transactions at issue were not publicly disclosed because a review of Defendants' financial information must be conducted in order to determine the constitutionality of Defendants' billings to Medicare. Whatever Defendant providers' financial records reveal will not determine the constitutionality of the bills submitted by Defendants to Medicare since such rates are calculated by Medicare carriers based upon a "reasonable charge" for the service. 42 C.F.R. § 405.502. Medicare does not review Defendants' financial data and, based upon such data, determine an appropriate rate to set for the provision of ambulance services. In any event, the financial data of Defendant providers herein was provided to the Counties with the proposals. (See Exhibits A, B, and C to Defendants' Reply Brief).

Appendix B

B. Original Source

Relators do not contend that they were the original sources of the transactions at issue herein, nor could they since they do not have "direct and independent knowledge of the information on which the allegations are based" since they do not work for Defendant service providers. 31 U.S.C. § 3730(e)(4)(B).

IV. CONCLUSION

For the reasons set forth herein, the Court finds that it lacks subject matter jurisdiction over this action because the "allegations or transactions" which form the basis of Relators' case were publicly disclosed and Relators were not the "original source" of such disclosure. Therefore, the Court grants Defendants' motion to dismiss this action based on lack of jurisdiction.

DATED: August 6, 1997

s/ James Ware
JAMES WARE
United States District Judge

APPENDIX C — RELEVANT CODES

Medi-Cal Payments for Medical Ground Transportation:

Excerpts from C.F.R. § 51527, Allied Health, August 1995.

HCPCS CODE	Description	Maximum Allowance
X0030	Ambulance service, Basic Life Support (BLS base rate, emergency transport, one way	$71.59
X0034	Ambulance service (BLS), per mile, transport, one-way	3.18
X0036	Ambulance service, oxygen, administration and supplies, life sustaining situation	9.88
X0006	Emergency run	9.88

* * * *

APPENDIX D — EXCERPTS FROM REQUEST FOR PROPOSAL

Excerpts from Report to Monterey County Board of Supervisors, Document #13 Appendix of Exhibits in Support of Motion of Defendants Med-Trans, Hartson Medical Services, Baystar Medical Services and Peninsula Paramedic Services, Inc. to Dismiss First Amended Complaint or, in the Alternative, for Summary Judgment:

"MONTEREY COUNTY / MONTEREY COUNTY EMERGENCY MEDICAL SERVICES AGENCY REQUEST FOR PROPOSAL FOR THE PROVISION OF EMERGENCY AMBULANCE SERVICE APRIL 1995."

* * *

[6] SECTION I-F. Minimum Requirements for Review

> All proposals will be initially screened by the County for completeness. Proposals that are not complete and do not meet the RFP requirements will be considered non-responsive and not further considered. The remaining proposals will be evaluated by a proposal review committee and the Monterey County Director of Health. The final selection will be made by the Board of Supervisors. The Board will either select a proposer or reject all proposals. A service contract will be offered to the selected proposer.

SECTION I-G. Cost, Revenue and Charge Review

> A significant emphasis in the selection process will be placed on cost, revenue and charge considerations. These

include: the quality and reasonableness of projections, description and commitment to provide verifiable revenue sources, and other patient revenue and patient charge projections. The ultimate objective of the review process is to define the provider who best meets the scope of service of this RFP, who is best able to demonstrate an integrated and quality ambulance system, who is best able to sustain the service over the life of the franchise, and has the most accurate analysis of costs and verifiable sources of revenue. Patient charges are a major component of establishing and maintaining a stable and long-term ambulance franchise. Excessively low-charge proposals, not justified in the RFP, will risk being defined as a "low-ball" proposal and be subject to exclusion. Charges that are below the Medicare "prevailing" charges will be carefully scrutinized. Minimizing costs to patients, as represented by patient charges, however, will remain a key consideration withing this framework.

* * *

[8] SECTION I-K. Confidentiality

Monterey County is subject to the California Public Records Act. The following RFP materials may be submitted in confidence, may remain confidential, and may be exempt from disclosure to the extent allowed by law: 1. Historical financial information of the proposing firm or entity; and, 2. materials related to the background investigation of the firm conducted under the RFP process.

* * *

Appendix D

[19] SECTION II F. ALS Level of Care

> The exclusive franchise holder will provide ALS level of care for all calls included within the exclusive franchise and ALS level of care or better for all other ambulance services provided in Monterey County during the contract term.

* * *

[76] SECTION IV – C. 12. j. Patient Charge System

Assignment: All proposers must agree to accept assignment from Medicare and Medi-Cal or have an acceptable alternative plan for handling hardship cases. Any alternative proposal must state and document historical experience to achieve the goal that no hardship will occur to the elderly or infirm or incapacitated who are unable to pay their deductibles or copays. Documentation should include past ratios, area demographics and other data documenting historical success in meeting this goal. As an alternative, proposers may agree to write off non-paid Medicare, Medi-Cal balances (where permitted by Medicare and Medi-Cal policy) where hardship circumstances apply. Appropriate policies to this effect must be included.

* * * *

APPENDIX E — EXCERPTS FROM REQUEST FOR PROPOSAL REVIEW COMMITTEE RECOMMENDATIONS

Excerpts from Report to Monterey County Board of Supervisors, Document #20 dated September 5, 1995, Appendix of Exhibits in Support of Motion of Defendants Med-Trans, Hartson Medical Services, Baystar Medical Services and Peninsula Paramedic Services, Inc. to Dismiss First Amended Complaint or, in the Alternative, for Summary Judgment:

"REQUEST FOR PROPOSAL REVIEW COMMITTEE RECOMMENDATIONS"

[1] ***Summary*** A Request for Proposal (RFP) for emergency ambulance service for Monterey County was distributed on April 7, 1995 to interested parties having submitted a Letter of Intent. On July 24, 1995, completed responses were received from three applicants: A-1 Ambulance Service, Inc., Carmel Regional Fire Ambulance (CRFA) and Peninsula Paramedic Services, Inc.

A five-member expert Proposal Review Committee, appointed by the Director of Health, met and conducted an extensive review of the proposals.

* * *

[9] **Cost and Charge Documentation**

Peninsula Paramedic Services, Inc. proposal offered a charge and subsidy system that, when all factors were considered, would provide for a stable, substantially compliant franchise

contractor. With their alternative lease arrangement, limited projections for fee increases over the life of the five year franchise (Peninsula Paramedic Services, Inc. used a 2.75 percent inflation adjustment to calculate future revenue sources), and willingness to accept assignment, that these factors would further reduce the charge and subsidy margin difference between the bidders and still guarantee a stable and quality contractor. The Peninsula Paramedic Services, Inc. provided a detailed budget that identified reasonable assumptions and projections which reflected their understanding of the service to be performed. One note, the Peninsula Paramedic Services, Inc. proposal did not stipulate a non-transport fee.

[Carmel Regional Fire Ambulance offer omitted.]

A-1 Ambulance Service, Inc. did not provide a CCT quote. Their proposed non-transport fee of $554 was higher than the proposed transport fee of $389 which did not appear reasonable to the Committee. Their projection for a 15 percent contractual write off and assumption that the government payers would subsidize the non-reimbursed portion up to the Medicare reimbursement rate (Monterey County was identified as a payor in their proposal) is not consistent with industry standards. Overall, the A-1 Ambulance Service, Inc. proposal did not appear to use realistic revenue projections for their assumptions. The Committee concluded that the Peninsula Paramedic Services, Inc. proposal was the strongest submission in terms of documentation and overall limited risk to the county.

* * *

Appendix E

[13-14] About the Emergency Proposal Review Committee

Kent Coxon

Mr. Coxon is the director of the EMS Agency of Sonoma County, CA and has been in that position for three years. Prior to that he was the Assistant EMS Director for Fresno County, CA EMS Agency for five years. Both counties have model performance based ambulance systems based on the Fail Safe Franchise Model. He spent 11 years with the City of Denver EMS system in a variety of field and management roles. He was recently a [*sic*] ambulance review panel member for the Portland area.

Garry MacPherson

Chief MacPherson is a former paramedic and current battalion chief of Poway, CA Fire Department. Until recently he was the EMS Coordinator for the department and had been in that position for seven years. He has been active in the EMS system development in San Diego County and has been a member of the ambulance review process committee for the City of San Diego for every selection process prior to the recent one (where the committee was selected from outside the county). He has a masters in public administration (MPA) with an emphasis on organizational design and human resources. He was recently a review panel member for the Portland area ambulance RFP process.

Janice Ogar, RN, MICN

Ms. Ogar is the base hospital nurse coordinator for Mercy Hospital and Medical Center, a large teaching hospital in

San Diego. She has been active in emergency department and prehospital care since 1979. She is current chair of CAL/ENA Prehospital Committee and is the designated liaison from CAL/ENA for EMSAAC.

Angelo Salvucci, MD

Dr. Salvucci is an emergency physician, medical director of the EMS system in Santa Barbara County and a teacher in emergency medicine at L.A. County/USC Medical Center. He was a reviewer for the recent San Diego City Ambulance and the Clackamas County (Oregon) RFP process. The Clackamas County ambulance contract is a fail-safe franchise system. He is currently president of the Emergency Medical Services Medical Directors Association of California (EMDAC).

Todd Valeri

Mr. Valeri is the general manager of American Ambulance of Fresno, CA. This company operates as an exclusive franchise provider for the greater Fresno area handling in excess of 50,000 calls per year. The company has been actively involved in RFP development and bid preparations. The Fresno franchise is considered a national model of a performance based, "Fail Safe" franchise. He was a review panel member for the recent Portland area ambulance RFP process. He has ten years field experience as a paramedic and has earned an MBA.

Appendix E

Financial Advisory Group:

Edward Perry

Mr. Perry is a senior project manager for David M. Griffith & Associates, a nationally recognized financial consulting firm to public entities. His experience ranges from conducting individual consulting projects for municipalities on revenue and costing to comprehensive projects for statewide organizations. He is an expert in health financing and problem resolution and is the lead consultant to the state of California on the Medical review project. He has provided technical assistance to The Abaris Group on several ambulance RFP projects. He has also provided extensive public agency consulting services in California (to organizations not involved in this bidding process). He was a review panel member for the recent Portland area.

Dave Elledge

Mr. Elledge is the Assistant Auditor-Controller for Monterey County and has been in that position for six months. He previously served as the Auditor-Controller-Recorder for Siskiyou County, a position he held for seven years. Prior to that he was employed as Audit Manager in the City and County Financial Reporting Bureau and the Property Tax Audit Bureau in the State Controller's Office Division of Local Government Fiscal Affairs.

* * * *

APPENDIX F — EXCERPTS FROM EMS STAFF AGENCY RECOMMENDATIONS

Excerpts from Report to Monterey County Board of Supervisors, Document #20 dated September 5, 1995, Appendix of Exhibits in Support of Motion of Defendants Med-Trans, Hartson Medical Services, Baystar Medical Services and Peninsula Paramedic Services, Inc. to Dismiss First Amended Complaint or, in the Alternative, for Summary Judgment:

"HEALTH DEPARTMENT MEMORANDUM FROM CHRIS LE VENTON TO ROBERT J. MELTON, M.D., MPH, DIRECTOR OF HEALTH. SUBJECT: STAFF ANALYSIS OF AMBULANCE PROPOSAL"

* * *

[11-12] 13. ***Costs/Charge recommendations.***

* * *

A-1.

A-1's charge structure includes a charge of $554 to be paid by the County for every non-transport response. A-1's charge structure also includes a proposal that, for all Medi-Cal and medically indigent adult patients, the County should pay the difference between the Medi-Cal or MCMSP reimbursement and the normal ALS charge that would have applied to the transport. The current Medi-Cal and MCMSP reimbursement rates for ambulance transports pay only a small portion of the total charge. This would result in a very high subsidy for these transports under A-1's proposal. A-1

further requests that the County pay to A-1 "as much as you have" in the form of the C.S.A. 74 subsidy. A-1 states that "For every dollar that the C.S.A. pays in advance, bills to patients will be reduced by a commensurate amount." Thus, the C.S.A. 74 subsidy, as a charge payable by the county, would be in addition to the non-transport fee and the Medi-Cal/MCMSP subsidy. The total county subsidy requested by A-1 far exceeds the $2.75 million requested for the non-transport fee. This money is simply not available.

A-1 refused to offer a rate for CCT services, stating that such a rate was "not calculatable." A-1's statement is not credible. It is clearly possible to determine roughly the cost of providing the CCT service and then allocate that cost to the CCT customers, either in whole or in part, in some reasonable manner. Neither of the other two proposers had any difficulty in proposing a rate for CCT services.

In addition, A-1 sets an extremely low ALS base rate. In all cases, the A-1 base rate would be lower than the approved Medicare rate. As a result, for these transports, Medicare would pay the lower rate, A-1 would not collect the maximum possible from Medicare, and the effect would be to pass off to the county the difference, in the form of the subsidy paid by the county to A-1 in lieu of the higher collection from Medicare.

CRFA.

[omitted]

Appendix F

Pen Med.

Pen Med's proposal sets forth all of the required rates and charges. Its rate schedule appears to be based on sound financial projections. One set of rates is based on the assumption that the three-way lease described in the RFP is used. A second set of rates, lower than the first, is based on the assumption that the alternative to the three-way lease proposed by Pen Med is used. In both of these sets, Pen Med differs from CRFA in that Pen Med does not charge separately for supplies but includes the cost of supplies within the basic rate.

* * *

Appendix F

[15-16] EMERGENCY AMBULANCE FEE/SUBSIDY STRUCTURE (CURRENT vs. PROPOSED) [CRFA omitted]

	Current	PenMed[1]	PenMed[2]	A-1
ALS base rate	$509.04	$598.53	$549.00	$369.00
supplies	$25 est.	included	included	included
non transport fee	$0	$0	$0	$554.00 (to be paid by the County)
assignment accepted	unknown	yes	yes	County to pay all ALS bills for Medi-Cal & MIA
C.S.A. 74 request	$591,175	$600,000	$600,000	"as much as you have"
other County subsidy	$0	$0	$0	[$2,753,934 nontransports plus all ALS bills for Medi-Cal & MIA patients]
average emergency ambulance bill	$714.50	$763.53	$714.00	$554.00

Appendix F

NOTES (numbered with reference to the line numbers in the table above)

1. The **PenMed**[1] column uses PenMed's proposed rate based on the three-way lease as specified in the RFP. The **PenMed**[2] column uses PenMed's proposed rate based on its proposed conditional lease.

* * *

12. ***Average emergency ambulance bill*** estimated as (ALS base rate) + (emergency fee) + (mileage fee X 7 miles) + (oxygen fee X 0.5) + (night fee X 0.3) + (supplies).

[These fees were fixed by Monterey County: Oxygen $55; emergency $57; mileage $11.50; night fee $0.]

* * * *

APPENDIX G — REQUEST FOR PROPOSAL ADDENDUM — MEDICARE REIMBURSEMENT

Excerpts from Written questions and answers submitted in connection with the April 19, 1995 Monterey County Bidders Conference, Document #18, Appendix of Exhibits in Support of Motion of Defendants Med-Trans, Hartson Medical Services, Baystar Medical Services and Peninsula Paramedic Services, Inc. to Dismiss First Amended Complaint or, in the Alternative, for Summary Judgment:

"MONTEREY COUNTY EMERGENCY
AMBULANCE RFP
ADDENDUM 1,
ATTACHMENT A — MEDICARE PROFILE"

CARMEL REGION AMBULANCE LOC 12 SPEC 59
AMBULANCE SERVICE SUPPLIER

TYPE SERVICE 9 DME/PSYCH/OTHER

CPT-4 NAT PROC MOD	CUST	PREV	50TH	IIC
A0370	561.52	562.43	562.43	459.73
A0390	11.02	11.02	11.02	8.71
A0422	51.19	51.19	51.19	32.60

* * *

Appendix G

A0370 Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed.

A0390 ALS mileage (per mile)

A0422 Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation

* * * *

APPENDIX H — RELEVANT STATUTES

CA Statutes, 1980, Chapter 1322, Section 1, p. 4605, provides in relevant part:

> The purpose of Sections 2 and 3 of this act, which respectively add Section 14106.6 to the Welfare and Institutions Code and amend Section 14132 of that code, is to give fiscal relief to local governments at a time when such governments are severely limited in their ability to raise funds for the continued provision of vital public safety services, such as paramedic services and, further, it is the intent of Sections 2 and 3 with respect to paramedic services that such relief does not necessitate increases in the overall costs to state government.
>
> The Legislature finds and declares that local governments are subsidizing the provision of paramedic services to indigents, including recipients eligible for the Medi-Cal program. Currently, the Medi-Cal program fails to make reimbursement for the provision of paramedic services, resulting in increased costs to local government. To the degree that paramedic services are provided to persons eligible for the Medi-Cal program, the state and federal government should pay for these services, and the director should make reasonable reimbursement. Further, it is the intent of Sections 2 and 3 with respect to paramedic services that there be no increase in overall state expenditures, since the increased state costs in Medi-Cal reimbursement

> for paramedic services should be offset by reductions in state costs of supporting local government in the aftermath of the passage of Proposition 13 at the June 6, 1978, statewide election.

CA Welfare & Institutions Code § 14132(r)(1) provides in relevant part:

> Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article. * * * (3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

CA Welfare & Institutions Code § 14106.6 provides in relevant part:

> The director shall establish and update annually a rate schedule of reimbursement for paramedic services which provides reimbursement based upon reasonable cost standards of the department.
>
> Notwithstanding any other provision of law, and to the extent federal financial participation is

available, any city, county, or special district providing paramedic services as set forth in subdivision(s) of Section 14132, shall reimburse the Health Care Deposit Fund for the state costs of paying such medical claims. Funds allocated to the county from the County Health Services Fund pursuant to Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code may be utilized by the county or city to make such reimbursement.

CA Health & Safety Code § 1797.52 provides:

"Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

Appendix H

CA Health & Safety Code § 1797.60 provides:

> "Basic life support" means emergency first aid and cardiopulmonary resuscitation procedures which, as a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available.

* * * *